

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

08125

★ Reg. Dist. No. 193

1. PLACE OF DEATH:

County Howard
City or town Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Howard
City or town Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. CP Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George W. Burdette

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Annie B. Burdette
7. Birth date of deceased (mo., day, yr.) Aug. 19, 1866 6. (c) If alive, give age _____ years
8. AGE: Years 80 Months — Days — If less than one day _____ hrs. _____ min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)
10. Usual occupation Farmer (Retired)
11. Industry or business
12. Name Allen Burdette
13. Birthplace Maryland
14. Maiden name Lucretia Lewis
15. Birthplace Maryland

16. Informant Mrs. Annie B. Burdette
Address Mt. Airy Md.
17. Burial (Burial, cremation, or removal, which?) Date thereof 8-31-46
(month) (day) (year)
Cemetery or crematory Poplar Springs
Location Howard Co. Md.
18. Funeral director Winters Mrs.
Address 8/21/1946
19. 8/21/1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1946 at 1:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9, 1946 to Aug 19, 1946
and that I last saw him alive on Aug 19, 1946
Immediate cause of death Coronary Thrombosis DURATION 9 da.
Due to _____
Due to _____
Other conditions Cardiac Asthma 4 da
6 hrs. Myocarditis 7 yrs
(Include pregnancy within 3 months of death)
Major findings of operations none Date of op. _____
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of Injury _____ Injured at work? _____
23. SIGNATURE J. Stanley Grubill M. D. or other
Address Fixing - Md Date signed 8/20/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINTAIN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

AUG 22 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 88a

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH

County... Howard Co
 City or town... Elkridge Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Howard
 City or town... Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Washington Blvd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clise S Gross
 4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

Edward Gross
 6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

July 6 - 1913
 8. AGE: Years 73 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace

Chambersburg Pa
 (town, county, and state)

10. Usual occupation

Retired home wife

11. Industry or business

12. Name James W Casgrove

13. Birthplace Chambersburg Pa

14. Maiden name Margaret A. Muse

15. Birthplace Unknown

16. Informant Edward Gross

Address Elkridge Md

17. Burial Date thereof Aug 14 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadow Ridge Cem

Location

18. Funeral director Chas P Towell

Address 2427 Edmondson Ave

19. 8/13/ 19 46 A. W. Hedrick

(Date read by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1946 at 1 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Aug 12 1946

and that I last saw him alive on Aug 12 1946

Immediate cause of death

Cerebral artery - 1

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45d

CERTIFICATE OF DEATH

08127

Reg. Dist. No. 194

1. PLACE OF DEATH:

County Howard
 City or town Glenelg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 51 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Glenelg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3.(a) FULL NAME

Charles Hart

3.(b) Social Security Number

- - - - -

4. Sex Male	5. Color or race Colored	6.(a) Single, married, widowed, or divorced Single
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6.(b) Name of husband or wife - - - - -
 B.(c) If alive, give age - - - years
 7. Birth date of deceased (mo., day, yr.) May 4, 1895
 8. AGE: Years Months Days If less than one day
51 3 10 _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Farm
 12. Name Henry Hart
 13. Birthplace Maryland
 14. Maiden name ?????
 15. Birthplace ?????

16. Informant Mitchell Johnson
 Address Ellicott City RFD, Md.

17. Burial Date thereof August 16, '46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Louis
 Location Clarksville, Md.
 18. Funeral director F.C. Higinbotham
 Address Ellicott City, Md.

19. 8/15/46 19. Marie G. Whitaker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 46 4:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 46 to August 13 19 46 and that I last saw him alive on August 13 19 46

Immediate cause of death Cachexia DURATION 2 mos.

Due to Carcinoma of the left mandible 8 mos.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles S. Whitaker, M.D. M.D. or other

Address Clarksville, Md. Date signed 8-15-46

AUG 17 1945
BUREAU. V. S.

1900

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

08128

P

Pinell L. Clinic CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
Howard Co. Rock Hill College
Ellicott City
 City or town (If outside city or town limits, write RURAL and give nearest town)
Howard Co.
 How long in above place of death
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 6 month

3. (a) FULL NAME John Heidelberg

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Anna Marie Heidelberg 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 9 - 1863
 8. AGE: Years 82 Months 9 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Catonville Md.
 (Town, county, and state)

10. Usual occupation Retired Grocery Merchant

11. Industry or business

12. Name Jonathan Heidelberg

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace Germany

16. Informant William Heidelberg
 Address 1200 Fred R Road Catonsville

17. Burial Date thereof Aug 26 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Louder Park Cemetery
 Location Baltimore Md.

18. Funeral director Marvin Cook Syfer
 Address 1600 W. North Ave.

19. 8/26/46 46 Autbeden
 (Date rec'd by Registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State md County Catonville
 City or town (If outside city or town limits, write RURAL and give nearest town)
 Street No. 208 Bloomsbury Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 19 46 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3 19 45 to Aug 23 19 46
 and that I last saw him alive on Aug 21 19 46

Immediate cause of death Hypostatic pneumonia DURATION 2 days

Due to Cerebral arteriosclerosis Unknown
Severe, C Sensitivity

Due to

Other conditions Bilateral inguinal Unknown
hernia
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Stephen Lee Magness M.D. M. D. or other

Address 752 Frederick Ave Date signed 23 Aug '46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08129/195

1. PLACE OF DEATH:

County HowardCity or town Savage
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 34 yrsHospital, institution, or street address where death occurred: Gulfport Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HowardCity or town Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. Box 42
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

EMMA JANE KEENEY

3. (b) Social Security Number

4. Sex F 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife James Albert Keeney7. Birth date of deceased (mo., day, yr.) Dec 14 1876 6. (c) If alive, give age 70 1/2 years8. AGE: Years 69 Months 6 Days 18 If less than one day
hrs. min.9. Birthplace Baltimore County, Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Bosson13. Birthplace Baltimore Co. Md.14. Maiden name Wilhelm15. Birthplace Baltimore Co. Md.16. Informant James Albert KeeneyAddress Savage, Md. Box 4217. Burial Date thereof 8-5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Savage CemeteryLocation Savage, Md.18. Funeral director Lloyd KaiserAddress 381 Main St. Laurel19. 8/3/46 19. Frank Shipley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 19 46, at 12:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 23rd 19 45 to Aug. 2nd 19 46and that I last saw her alive on Aug. 2nd 19 46Immediate cause of death Ac. Card. Distention DURATION 1 hrDue to HypertensiveCardio-Vascular Disease - 1 yr.Due to ✓Other conditions ✓

(Include pregnancy within 8 months of death)

Major findings of operations ✓

Date of op.

Antopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.Address Savage, Md. Date signed 8/3/46

RECEIVED
AUG 7 1946
BUREAU V.S.

81	9	69
71	21	9231
2	8	7461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County... HOWARD
 City or town... ELLICOTT CITY MD
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Howard
 City or town... ELLICOTT CITY
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ROGERS AVE
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

ROSE C KRAFT

3. (b) Social Security Number

4. Sex FEM 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOW

6. (b) Name of husband or wife JOHN KRAFT.

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 15 1870

8. AGE: Years 75 Months 10 Days 21 If less than one day
 hrs. min.

9. Birthplace PA
(Town, county, and estate)10. Usual occupation NONE

11. Industry or business

12. Name CHARLES. PREINES13. Birthplace GERMANY14. Maiden name ROSE BECK15. Birthplace GERMANY.16. Informant PAUL KRAFT.Address ROGERS AVE ELLICOTT CITY MD

17. BURIAL Date thereof 8-7-46
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory BALTIMORE CEMLocation BALTO. MD18. Funeral director Bernard G. HarboAddress 121 E WEST ST

19. 8/5 46 A. W. Nedwell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1946 at 4A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Aug 5 1946and that I last saw him alive on Aug 5 1946

Immediate cause of death Coronary artery disease with generalized metastases
 DURATION 1 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Schuman M. D. or otherAddress Cherry Hill Date signed 8/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

08131

Reg. Dist. No. 191

1. PLACE OF DEATH:

County... Howard
 City or town... Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs
 Hospital, institution, or street address where death occurred:
Bonnie Branch Rd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County... Howard
 City or town... Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Bonnie Branch Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war... none

3. (a) FULL NAME

Charles Richard Lowe

3. (b) Social Security Number

none

4. Sex... Male 5. Color or race... white 6.(a) Single, married, widowed, or divorced... married
 6.(b) Name of husband or wife... Lattie King Lowe 6.(c) If alive, give age... 74 years
 7. Birth date of deceased (mo., day, yr.)... Feb 28 1867
 8. AGE: Years... 79 Months... 5 Days... 11 If less than one day... hrs. min.

9. Birthplace... Manassas, Va.
 (Town, county, and state)
 10. Usual occupation... Farmer
 11. Industry or business... Retired
 12. Name... John Thomas Lowe
 13. Birthplace... va
 14. Maiden name... Mary Cooper
 15. Birthplace... va

16. Informant... Mrs. Marie Ash (Daughter)
 Address... Ellicott City, Md
 17. Burial... Burial Date thereof... Aug 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Cedar Hill
 Location... Lanham, Md.
 18. Funeral director... Easton Sons
 Address... Ellicott City, Md.

19. Aug 8, 1946 John B. Loughman
 (month) (day) (year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug 8 1946, at 1 P. M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 6 1946 to Aug 8 1946
 and that I last saw him alive on Aug 7 1946
 Immediate cause of death... Chr Myocarditis 3mo
& Decompensation
 Due to... Gen arteriosclerosis
 Due to... Senility
 Other conditions... Ch Bronchitis 3mo
 (Include pregnancy within 8 months of death)
 Major findings of operations...
 Date of op. ...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... AB Brown
Elbridge M. D. or other
 Address... Date signed Aug 8/46

RECEIVED
AUG 10 1946
BUREAU V.B.

Permanently
RECEIVED
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 312

CERTIFICATE OF DEATH

08132
195
Reg. Dist. No.

1. PLACE OF DEATH:

County... Howard
City or town... Guilford Road, Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, institution, or street address where death occurred:
How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Howard
City or town... Guilford Rd. Route # 1, Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George Paul Seebold

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Emma Seebold
6. (c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) Dec 17, 1870
8. AGE: Years 75 Months 8 Days 10 It less than one day hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business

12. Name Unknown
13. Birthplace Germany
14. Maiden name Unknown
15. Birthplace Germany
16. Informant Adelaide Seebold
Address Guilford Rd Route #1 Ellicott City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30, 1946 (month) (day) (year)
Cemetery or crematory Meadowridge Memorial Park
Location Howard Co

18. Funeral director Ridgely Selby
Address 401 Wash Ave, Laurel Md
8/29/46
19. (Date rec'd by registrar) 19 8/28/46
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16, 1946, to August 16, 1946, and that I last saw him alive on August 16, 1946.

Immediate cause of death General debility, malnutrition

DURATION

2 months

Due to Carcinoma of nodulate gland metastases to liver & lungs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Stephens, MD

Address 305 Prince George St. M.D. or other 8/28/46.

Date signed

REC-100
SEP 3 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 08133 195

1. PLACE OF DEATH:

County HowardCity or town Scaggsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 77 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town Scaggsville, Laurel Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Frances Souder

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FWWidowed6.(b) Name of husband or wife George T. Souder7. Birth date of deceased (mo., day, yr.) 11-21-1868 6.(c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
77 9 2 _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation housewife11. Industry or business home12. Name William T. Murphy13. Birthplace Maryland14. Maiden name Elizabeth Tager15. Birthplace Maryland16. Informant Amos SouderAddress Laurel, R. F. D. Md.17. Burial Date thereof Aug. 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Emanuel Cent'yLocation Scaggsville, Md.18. Funeral director DeWitt DonaldsonAddress Laurel, Md.19. 8/24/46 Shank Shipley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1946 at 1 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1946 to Aug 23 1946 and that I last saw her alive on July 2 1946Immediate cause of death Acute Cardiac Dilatation 1 hrDue to Hypertension 10 yrsDue to Arteriosclerosis 10 yrsOther conditions ✓

(Include pregnancy within 8 months of death)

Major findings of operations ✓

Date of op. _____

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

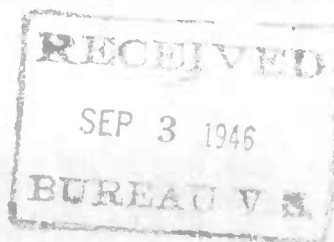
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Warren M.D. M.D. or otherAddress Laurel Md Date signed 8/24/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:

County... Howard
 City or town... rural - Highland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
Lowland Farm
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Howard
 City or town... rural - Highland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Lowland Farm
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

LILLIE GENEVIA WILLIAMS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sprinkle Williams
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) October 4, 1883
 8. AGE: Years 62 Months 9 Days 7 If less than one day
 hrs. min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name Frank Anderson
 13. Birthplace Virginia
 14. Maiden name ????
 15. Birthplace Virginia

16. Informant Sprinkle Williams
 Address Highland, Md.
 17. removal & burial Date thereof August 12, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Round Hill
 Location Marion, Va.
 18. Funeral director F.C. Higinbotham
 Address Ellicott City, Md.
 19. 8/11 1946 Marie A. Whitaker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1946 at 12:30 P
 21. I CERTIFY that death occurred on the data above stated; that I attended deceased from June 22 1946 to August 11 1946
 and that I last saw her alive on August 11 1946
 Immediate cause of death Acute cardiac failure DURATION 24 hrs.
 Due to Chronic valvular endocarditis 10 yrs.
 Due to
 Other conditions Carcinoma cervix with metastases 2 years
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D. M. D. or other
 Address Clarksville, Md. Date signed 8/11/46

RECEIVED

AUG 13 1946

BUREAU V S